General

Guideline Title

Role of endoscopy in the management of GERD.

Bibliographic Source(s)

Standards of Practice Committee, Lichtenstein DR, Cash BD, Davila R, Baron TH, Adler DG, Anderson MA, Dominitz JA, Gan SI, Harrison ME 3rd, Ikenberry SO, Qureshi WA, Rajan E, Shen B, Zuckerman MJ, Fanelli RD, Van Guilder T. Role of endoscopy in the management of GERD. Gastrointest Endosc. 2007 Aug;66(2):219-24. [41 references] PubMed

Guideline Status

This is the current release of the guideline.

The American Society for Gastrointestinal Endoscopy (ASGE) reaffirmed the currency of the guideline in 2011.

Recommendations

Major Recommendations

Recommendations were graded on the strength of the supporting evidence (Grades 1A-3). Definitions of the recommendation grades are presented at the end of the "Major Recommendations" field.

Summary

Gastroesophageal reflux disease (GERD) can be diagnosed on the basis of typical symptoms without the need for diagnostic testing, including endoscopy (1C).
In patients with uncomplicated GERD, an initial trial of empiric medical therapy is appropriate (1C).
Endoscopy is recommended for patients who have symptoms suggesting complicated GERD or alarm symptoms (2A).
Endoscopic findings of reflux esophagitis should be classified according to an accepted grading scale or described in detail (3).
Endoscopy should be considered in patients at risk for Barrett's esophagus (BE) (2C).
Biopsy must be performed to confirm endoscopically suspected BE (2B).
Endoscopic biopsy specimens should not be obtained from an endoscopically normal tissue to exclude BE (2B).
For patients with established BE of any length and with no dysplasia, after 2 consecutive examinations within 1 year, an acceptable interval for additional surveillance is every 3 years (3).
Endoscopic antireflux therapy may be considered for selected patients with uncomplicated GERD after careful discussion with the patient regarding potential side effects, benefits, and other available therapeutic options (3).

Definitions:

Grades of Recommendation*

Grade of Recommendation	Clarity of Benefit	Methodologic Strength/ Supporting Evidence	Implications
1A	Clear	Randomized trials without important limitations	Strong recommendation; can be applied to most clinical settings
1B	Clear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Strong recommendation; likely to apply to most practice settings
1C+	Clear	Overwhelming evidence from observational studies	Strong recommendation; can apply to most practice settings in most situations
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	Randomized trials without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Weak recommendation; alternative approaches may be better under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; alternative approaches likely to be better under some circumstances
3	Unclear	Expert opinion only	Weak recommendation; likely to change as data become available

*Adapted from Guyatt G, Sinclair J, Cook D, Jaeschke R, Schunemann H, Pauker S. Moving from evidence to action: grading recommendations—a qualitative approach. In: Guyatt G, Rennie D, eds. Users' guides to the medical literature. Chicago: AMA Press; 2002. p. 599-608.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Gastroesophageal reflux disease (GERD)
Complications of GERD such as Barrett's esophagus (BE)

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Gastroenterology

Internal Medicine

Intended Users

Physicians

Guideline Objective(s)

To discuss the use of endoscopy for the diagnosis and management of gastroesophageal reflux disease (GERD) and Barrett's esophagus (BE)

Target Population

Patients with gastroesophageal reflux disease (GERD) and Barrett's esophagus (BE)

Interventions and Practices Considered

- Esophagogastroduodenoscopy (EGD)
- Biopsy
- Classification of gastroesophageal reflux disease (GERD) according to an accepted grading scale (the Los Angeles classification or the Savary-Miller classification) or detailed description of endoscopic findings
- Endoscopic antireflux therapy for selected patients

Major Outcomes Considered

- Accuracy and specificity of diagnostic tests
- Incidence and economic impact of gastroesophageal reflux disease (GERD)
- Cost-effectiveness of endoscopic evaluation, screening and/or treatment
- Safety of endoscopic procedures

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

2007 Guideline

In preparing this guideline, a search of the medical literature was performed using PubMed, supplemented by accessing the "related articles" feature

of PubMed. Additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When little or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts.

2011 Reaffirmation

A search of medical databases (PubMed, MEDLINE) and annual meeting proceedings from 1990 to 2011 was conducted by one to two Standards of Practice Committee members.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

2007 Guideline

Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus.

2011 Reaffirmation

A search of medical databases and annual meeting proceedings was conducted by one to two Standards of Practice Committee members with discussion and voting regarding novelty and informative value of new publications since the previous version of the guideline.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation*

Grade of Recommendation	Clarity of Benefit	Methodologic Strength/ Supporting Evidence	Implications

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Cost Analysis

Published cost analyses were reviewed.

A landmark modeling study showed that a strategy of endoscopic screening for Barrett's esophagus (BE) in 50-year-old white males with gastroesophageal reflux disease (GERD) followed by subsequent endoscopic surveillance for those with dysplasia was associated with acceptable costs per quality-adjusted life year saved. Several other modeling studies reached similar conclusions regarding screening for this specific population but differed regarding the cost effectiveness of additional surveillance in patients with nondysplastic BE.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This document was reviewed and approved by the Governing Board of the American Society for Gastrointestinal Endoscopy.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified for each recommendation (see "Major Recommendations").

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate utilization of endoscopy in the diagnosis and management of patients with gastroesophageal reflux disease (GERD) and Barrett's esophagus (BE)

Potential Harms

Drawbacks of esophagogastroduodenoscopy (EGD) include the potential physical risks, financial costs, and limited access to the procedure.
Short- and long-term safety issues surrounding the endoluminal devices continue to be a concern, and the economics of their use are unknown.

Qualifying Statements

Qualifying Statements

Further controlled clinical studies are needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.
This guideline is intended to be an educational device to provide information that may assist endoscopists in providing care to patients. This guideline is not a rule and should not be construed as establishing a legal standard of care or as encouraging, advocating, requiring, or discouraging any particular treatment. Clinical decisions in any particular case involve complex analysis of the patient's condition and available courses of action. Therefore, clinical considerations may lead an endoscopist to take a course of action that varies from these guidelines.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2007 Aug (reaffirmed 2011)

Guideline Developer(s)

American Society for Gastrointestinal Endoscopy - Medical Specialty Society

Source(s) of Funding

American Society for Gastrointestinal Endoscopy

Guideline Committee

Standards of Practice Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

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Guideline Availability

Electronic copies: Available from the American Society for Gastrointestinal Endoscopy Web site .

Print copies: Available from the American Society for Gastrointestinal Endoscopy, 1520 Kensington Road, Suite 202, Oak Brook, IL 60523

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on March 3, 2008. The currency of the guideline was reaffirmed by the developer in 2011 and this summary was updated by ECRI Institute on October 16, 2012.

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